A brief history of (residential child care) ethics

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Introduction

When I started working in residential care in 1981 I considered my job to be a vocation. By the time I left, 19 years later, ideas of vocation had become suspect, as had personal relationships. Instead, a host of what Stephen Webb calls 'technologies of care', ideas of 'evidence-based-practice' or 'best practice', had reduced the relational and holistic nature of care to a series of administrative tasks. This brave new world was said to represent progress, modernisation, professionalism and a host of other hurrah terms. I couldn't help but think we had lost a lot along the way.

During my time as course director of the MSc in Advanced Residential Child Care, I discovered Moss and Petrie's (2002) book, 'From children's services to children's spaces'. It began to make sense of the unease I felt about the direction residential child care had taken or been taken in. It was something of an epiphany; we were playing on the wrong ballpark altogether. Moss and Petrie argue that residential child care is

fundamentally, irredeemably, a moral endeavour, yet it has, over time been reframed as a technical-rational one.

Getting students to buy this notion of residential child care as, primarily, a moral task wasn't always easy. I remember, in the course of my early attempts to introduce such ideas, being told by a seasoned campaigner that I was going too far this time. He had a point; rethinking residential child care as a moral endeavour can be almost counter intuitive, challenging an Enlightenment inheritance (of which more later), which leads us to seek rational and prescriptive solutions to human problems. Reframing these problems as moral ones requires that we put a stutter into dominant narratives that would have us believe that warmly persuasive ideas of 'improvement' and 'modernisation' can be achieved through ever-more prescriptive practice standards, codes of conduct, and their attendant regulatory apparatus. It also requires that we put aside the conceit and the false certainty promised, but incapable of being delivered, by such technical-rational fixes. Paradoxically, it begins to implicate the quest for such fixes in many of the problems encountered in residential child care. This position is increasingly recognised in the social work literature, where there has been a discernible turn to ethics as a counterweight to technical and managerial ways of working (e.g Meagher and Parton, 2004, Webb 2006) and indeed in the literature on residential child care (Smith, 2009).

So what are ethics?

The term 'ethics' can be used in different ways, often interchangeably with moral philosophy. Basically it is the study of the norms and standards of behaviour people

follow concerning what is good or bad, right or wrong. There are three main branches of ethics: meta-ethics, which concerns the big questions of where our ideas of good and bad, right and wrong might come from; normative ethics, which attempt to offer principles that might guide our moral conduct in particular situations and applied ethics, which examine specific issues. Examples of such issues in residential care might include personal touch or physical restraint.

Starting at the beginning

This article sketches some ethical ideas and frameworks as they relate to residential child care over time. In attempting such a historical sweep I am nothing if not ambitious, starting at a meta-ethical level with Adam and Eve, or at least with their offspring, Cain and Abel. When God said to Cain, 'Where is your brother?' Cain replied 'I know not. Am I my brother's keeper?' In this retort Cain, according to the sociologist Zygmunt Bauman, introduced the seeds of immorality into the human condition. Of course Cain is his brother's keeper; it is part and parcel of what makes him (and us) human. Being human is an orientation to 'the other'. 'I am a moral person because I recognise my brother's dependence and accept the responsibility that follows (Bauman, 2000: 1). These two words, dependence and responsibility are central to moral comportment. Ironically, ideas of dependence and the infinite responsibility that follows from it have come to be avoided in much professional social work. To be professional nowadays can seem to be about promoting independence and not becoming emotionally involved.

Beginning any exploration of how ethical ideas relate to care with a Bible story is perhaps fitting. Until very recently the human call to care was essentially a religious one, epitomized perhaps in the Christian tradition in the story of the Good Samaritan who crossed to the other side of the road to reach out to a stranger in need. Do you love me…? The Bible asks … 'Feed my lambs … Take care of my sheep'. Again, this is a tradition that can appear alien within the public if not always the private sphere of contemporary social work, although there may be some signs of a shift in this regard. Keith White (2008), for instance, resurrects ideas of 'love' and God' in recent writing on residential care.

Of course the call to care isn't unproblematic; it can be abused, through either design or neglect. A persistent tension emerges between the desire to support a selfless reaching out to the other and the perceived need to guard against the excesses or abuses that engagement with the other can open the way for. In some respects what side we come down on in this debate may reflect our own more fundamental experiences and understandings of human nature and human relationships. All relationships exist somewhere along a continuum of love and fear (Smith, 2008). The dominant impulse in recent decades has been one of fear, reflected in a tendency to deal with increasing fragmentation and uncertainty in society by imputing the worst in human relationships. Thus, we witness the proliferation of regulation, predicated upon an atavistic belief that this is required to prevent social care workers abusing those they work with (McLaughlin, 2008).

The Enlightenment

This tension between the innate badness or goodness of human nature is not new. Thomas Hobbes, an early Enlightenment thinker, identifies human nature as instinctively base and selfish and requiring some external power to keep it in check. But there were other strands of Enlightenment thought, much of it emanating from Scotland.

The Enlightenment was a period of intense scientific and philosophical activity that swept across Europe over the course of the 17th and 18th Centuries. It marks the beginning of the 'modern' period in human history. Scottish Enlightenment thinkers reflected what was essentially an optimistic view of human nature. Francis Hutcheson, Professor of Moral Philosophy at the University of Glasgow, identified in human nature what he considered to be almost a sixth sense, that of benevolence. Adam Smith, better known perhaps for his contribution to economics was also a moral philosopher and he identified an innate sympathy in the human condition, while David Hume observed a human predilection towards doing good, noting that virtue brings with it a sense of pleasure and vice a feeling of pain. Our feelings, therefore, provide a natural guide for moral conduct. The Scottish Enlightenment thinkers, however, came out on the losing side in moral thinking in the eighteenth century (Tronto, 1994).

Two 'winning' ethical approaches emerged from the Enlightenment, both normative in the sense that they sought to set overarching principles to guide moral behaviour. One of these was utilitarianism, associated with the English radicals Jeremy Bentham and John Stuart Mill. Utilitarianism decreed that the touchstone for moral decision-making ought

to be a calculation of the greatest good. It is oriented towards the consequences of actions rather than the actions themselves.

The other winner in Enlightenment ethical thinking was the Prussian philosopher Immanuel Kant. Kant, famously, claimed that Hume awakened him from his dogmatic slumbers. Our understanding of ethics would have been very different had Hume left Kant to sleep.

Kant believed that, rather than being driven to act in a moral way by virtue of some innate sense of benevolence or sympathy, human beings used reason to determine how they ought to behave. They were considered to be rational, autonomous individuals. Kant also formulated his categorical imperative, which decreed that what was considered right in one situation should apply more universally. There is little room for context in Kant's ethics.

Within a Kantian frame of reference ideas of care are reduced to a sense of duty (Kant's ethics are deontological or duty based). If one accepts a role as a carer this carries with it certain duties. Workers are to act upon those duties rather than upon any more emotionally grounded call to care. The notion of care as a duty perhaps reaches its apogee in the Regulation of Care (Scotland) Act (2001). This sets out where care is to be provided, by whom and the penalties for failing to provide it. Nowhere, however, does it get close to defining what might be meant by care.

Following Kant, rationality became the touchstone of human conduct despite Hume's prescient observation that reason could only be the slave of the passions. Social work ethics have largely developed around Kantian principles, stressing universality, objectivity, reason, legalism and proceduralism (Clark, 2000). As Sewpaul observes:

> *Given its birth during the period of modernity with its emphasis on reductionist, logical positivist rationality, ... social work took on this dominant discourse in the pursuit of status and professionalism. To this end we have seen codified systems of ethics, the move towards greater standardisation and competencies development, ...systems of accreditation,... and an increase in the development and use of professional jargon* (2005:211).

The professionalisation of residential child care

The professionalisation of social work following the 1968 Social Work (Scotland) Act and the declaration that followed, claiming residential care to be a branch of social work, reinforced a particular view of what it was to be 'professional'. Social workers were not to be 'diverted by their personal beliefs and convictions or by emotions - sympathy or antipathy - to fellow workers or to individual clients ....' . Actions 'should not be oriented to persons at all, but to the rules … (Bauman, 1994: 5).

The nature of care itself shifted from what was essentially a private and largely domestic task to become more public and ostensibly professional. This saw a shift away from the 'aunties' and uncles' and live-in staff who had been at the heart of models of family

based care to what Douglas and Payne (1981) term an industrial model. In this the personal and professional selves of carers became separated, on the one hand by structural changes such as the introduction of shift systems, but also by discourses that made particular assumptions of what it was to be 'professional'. Thus, ensuring that children had clean socks and brushed their teeth regularly was not considered to be 'professional' but counselling them around particular difficulties was. The focus of care shifted from the 'soul' of erstwhile religiously based care to the 'psyche' of a more secularized version. And dealing with the 'psyche' called for the imposition of a 'professional' distance between the carer and the cared for. Erstwhile notions of care became suspect; social work discourses of independence, empowerment and anti-institutionalisation became totems of a profession that could consider itself 'so tainted by its associations with care that the word should be expunged from its lexicon and its rationale' (Meagher and Parton, 2004: 4).

Interestingly, contemporary commentators observed that 'neither staff nor residents have really benefited from the introduction of industrial practices and conditions to human service organisations' and that' staff, through no fault of their own, have given up trying (Douglas and Payne, 1981). I will return to what I consider to be an explanation for why staff might give up trying but before doing so I will address some of the issues raised by what have become the dominant ideologies that have come to frame residential care within social work, specifically those of rights and protection. We are encouraged to believe that such concepts are self-evidently 'good things' and that they need to be enforced through codification. Yet the very notions of children's rights, child protection

and a faith in codes of practice to enforce these betray a rationalist conceit and, moreover, reflect an essentially misanthropic view of human nature.

Rights, protection and codes

Children's rights, as they have emerged in public policy, derive from an essentially Kantian view of human nature, 'premised on particular values and a particular understanding of the subject as a rational, autonomous individual' (Dahlberg and Moss, 2005: 30). By this way of thinking we become linked to one another through a series of contractual relationships rather than anything deeper. Specifically, there is little sense of community and inter-dependence within rights discourse, yet, paradoxically, true freedom only emerges from what the French philosopher Emanuel Levinas terms heteronomy, a sense of community and responsibility for the other.

Protection, similarly, betrays a particular take on human relationships. It 'involves a very different conception of the relationship between an individual or group, and others than does care. Caring seems to involve taking the concerns and needs of the other as the basis for action. Protection presumes … bad intentions …. (Tronto 1994: 104). Assumptions that derive from ubiquitous child protection discourses have been instrumental in the creation of climates of fear and suspicion within child care settings and have seriously limited carers' capacity to care.

These dominant discourses of rights and protection have become reified in various codes and standards. The regulation of care legislation is premised upon a reductionist

assumption of a need to 'protect' service users, rather than anything more aspirational. This goal of protection is to be achieved through codes and standards. However, these too are

> *'negative rather than positive, products of fear rather than a characteristic of a confident profession or workforce'. Codes give no space for context or good professional sense, and so were generally 'ignored or became unworkable', creating 'guilt at their non-compliance'* (Piper, 2006).

The self-serving nature of regulation based around contestable discourses of rights and protection reflects the spirit of our age, that age being one that no longer believes in modernity's promise of steady progress and that spirit being one of fear, concerned to avoid things going wrong rather than with articulating any more hopeful vision of the future. This fear is evident in hyper-proceduralism. It is almost as if we recognise that procedures are not working, but rather than draw the conclusion that they might in fact be part of the problem, the 'rational' mindset seeks to address this problem through recourse to ever-more 'technical' solutions. The results of this are all too apparent to practitioners forced to spend more and more time writing about children rather than being with them, exhorted by regulators to believe that if something hasn't been written down it hasn't happened. Such a mindset is highlighted in the following quote from a magazine feature comparing children's homes in England and Germany.

> *Staff are expected to keep three simultaneous daily logs. The first is a handwritten diary noting movements of staff and children in and out o the home; no Tipp-Ex*

corrections are allowed and all unused parts of pages must be crossed through and initialled. The second is a round-the-clock record of the children's activities and staff registering, for instance, if a child gets up for a glass of water in the night. The third is an individual log compiled each day for each child, noting their activities and behaviour. All these logs and diaries must be stored for a minimum of 75 years - partly in case a child makes an allegation of abuse against a care worker. So many need to be held onto that thousands are kept at a disused salt mine in Kent. (Sunday Times 18th March, 2007).

This scenario is, paradoxically, a product of ostensibly 'rational' minds. It perhaps raises questions as to whether it is just documents that ought to be consigned to salt-mines in Kent or even further afield. It also takes us to the nub of the matter in terms of considering an appropriate ethical understanding of care. Care, according Levinas, has to be exercised face to face without intermediaries. When so many procedural intermediaries circumscribe care, its very essence is compromised. Bauman argues that '.... when we obscure the essential human and moral aspects of care behind ever more rules and regulations we make the daily practice of social work ever more distant from its original ethical impulse' (Bauman, 2000 p.9).). By this reckoning the plethora of rules and regulations that increasingly surround practice are not just minor but necessary irritants; they act to dull the moral impulse to care. This, perhaps, goes some way to explaining why workers give up trying.

Alternative ethical frameworks

The difficulties inherent in overly proceduralised approaches to practice calls for an exploration of alternative ethical frameworks within which to consider care. The wider 'turn' in ethics is away from a reliance on the normative ethics provided by Kantian and utilitarian approaches. There is a growing interest in care ethics and a resurgent interest in virtue ethics both of which may point a way forward in offering more appropriate ways of thinking about care.

Care ethics

Carol Gilligan was a research student of Lawrence Kohlberg who developed what has become a standard theory of moral development. According to Kohlberg, women rarely achieved his highest stage of moral development. Gilligan (1982) reinterpreted his data to argue that, rather than being less moral than men, women applied different ways of thinking to moral decision making; they spoke in a different moral voice, one that emphasised qualities of care, compassion, context and intuition. Men, by contrast, inclined towards decision-making based around qualities of justice, objectivity and reason. From Gilligan's initial work a whole literature has built up around what has become known as care (or feminist) ethics.

An ethic of care, according to Joan Tronto, one of its most influential proponents, is 'a practice, rather than a set of rules or principles…It involves both particular acts of caring and a 'general habit of mind' to care that should inform all aspects of a practitioner's

moral life' (Tronto 1994, pp126/7). It is both an activity and a disposition. Care ethics eschew Kant's universalism being bound to concrete situations, rather than being formal and abstract. (Sevenhuijsen 1998). They demand a way of caring that challenges the expectation that carers are dispassionate and objective, taking '... professional caring into the personal realm and requir(ing) that both parties show up, be present, be engaged at a feeling level for each other. The presence of feeling(s) provides the link which connects the worker and client. Very simply put, without this connection, without the feeling(s) in the relationship, the people do not matter to each other (Ricks, 1992). Henry Maier (1979) makes a similar point arguing that physical care needs to be transformed to caring care. By means of example, workers might think of the act of getting children up in the morning. Anyone can wake a child and tell them to get out of bed but to perform this act in a caring way might involve the worker knowing the particular likes and preferences and rhythms of an individual child and responding to these. This can only happen when the 'self' of the carer becomes central to the experience of care. Care becomes enacted and meaningful in relational rather than instrumental terms. Care ethics are increasingly identified as an ethical paradigm that can challenge procedural ways of thinking and acting (Meagher and Parton, 2004).

Virtue ethics

Another approach that challenges dominant normative ethics is that of virtue ethics, Associated with the ancient Greek philosopher, Aristotle, virtue ethics are oriented towards human flourishing and a conception of 'the good life'. They locate morality within the personal characteristics of the moral actor rather than in the duties imposed by

abstract rules. And, of course, there are those people each of us might identify as exemplifying virtues of care and who we might be happy to have care for us. Children in care, too, can pick out those who truly care for them. David, a respondent in Cree and Davis' book exemplifies this point, noting 'There were people who really cared and that shone through; and there were people who didn't care and that also shone through' (2007: 87). And then, 'There was a nun, who was the head nun of our children's home who was very, very fair, and kind, but not in a 'goody-goody' way – she was a just person, and she offered us protection' (2007:87). Good care, from a virtue ethics perspective, is dispositional; it cannot be separated from the 'self' of the carer.

Conclusions

So what tentative conclusions might we draw from this consideration of ethical approaches as they relate to care. Firstly, approaching care from an ethical rather than a technical-rational standpoint throws up some fundamental disjunctions between the way that care is currently conceptualized and managed and any sustainable understanding of what care actually involves. An obvious disjunction is that public care is provided, directly or indirectly, by organizations that profess rationality. Yet, care is not rational. According to Bauman, 'There is nothing reasonable about taking responsibility, about caring and being moral (Bauman 2000: 11). Caring involves 'being for' the other and assuming the personal responsibility that follows from this. This may require carers to go against convention, to cross to the other side of the road to reach out to someone that the procedures manual might identify as dangerous or 'a risk'. Care cannot be reduced to the rational prescriptivism imposed by the procedures manual or the risk assessment.

The wider point here may be that normative ethical theories are inadequate in providing a guide to practice that is rarely clear-cut but is, by its nature, messy and ambiguous (Bauman, 1993). In that sense merely following the rules is insufficient. As Ricks and Bellefeuille note:

> *Codified rules of what to do in particular cases and cases of like kind, gets us off the hook of moral endeavour…Adherence to codified rules does not necessarily require self-awareness or accountability for taking a moral stance. It simply requires learning the rules and following them…*
>
> (2003:121)

Merely following the rules in complex areas of practice can be dangerous and oppressive. Policy makers, managers and indeed care workers would do well to relinquish the quest for some elusive 'best practice' and to become comfortable with uncertainty; care requires reflexive and morally active practitioners rather than unquestioning followers of rules. This, of course, demands a radical turnaround, away from relationships based around fear to those based around love. Again, Bauman offers some philosophical rationale for this arguing, perhaps following the lead of the Scottish Enlightenment philosophers, that there is an innate goodness in humankind. We are not good because of societal rules and impositions; rather society exists because individuals are capable of and carry out good and caring acts on a daily basis.

In many respects care needs to move away from normative ethical frameworks, with their false promise of some elusive 'best practice' and to consider meta-ethical frameworks and applied ethical debate. Meta-ethics, to recap, addresses the big picture such as what might a 'good life' look like, what are our hopes for our children and what kind of relationships do we want with them? Applied ethical debates might take us toward how we might help children move towards this notion of the good life in our caring interactions. What constitutes good care needs to be worked out in concrete situations amongst the cared for and those caring. Care that is divorced from the caring relationship can, according to Noddings, 'become self-righteous and politically correct. It can encourage dependence on abstraction and schemes that are consistent at the theoretical level but unworkable in practice' (2002 p.22/23). Workers in residential care will recognise this tendency. This makes it all the more important that those who know residential care need to be at the heart of ethical debates around what it should be like. And those debates need to have at their heart a notion of care that centres around the personal relationship between the cared for and the one caring, with all the complexity and duplicity that this entails. We need to provide care settings that allow such relationships to emerge and to flourish.

A starting point in these debates might be to consider a different vocabulary to help us frame what it is we do and what it is that we hope. Perhaps it is time to put aside simplistic and individualised conceptions of rights, to put aside protection, risk, risk assessment, 'best practice', codes, standards and to consider a vocabulary that speaks a different language with regard to children. Moss and Petrie offer some possibilities:

Joy, spontaneity, complexity, desires, richness, wonder, curiosity, care, vibrant, play, fulfilling, thinking for yourself, love, hospitality, welcome, alterity, emotion, ethics, relationships, responsibility — … are part of a vocabulary which speaks about a different idea of public provision for children, one which addresses questions of the good life.' (2002, p.79).

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